Case Number:	CM13-0070950		
Date Assigned:	01/08/2014	**Date of Injury:**	04/12/2002
Decision Date:	04/22/2014	**UR Denial Date:**	12/16/2013
Priority:	Standard	**Application Received:**	12/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York and Tennessee. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 64-year-old female who was injured on April 12, 2002. The patient continued to experience bilateral knee pain, low back pain, right shoulder pain, and right carpal tunnel syndrome. Physical examination was notable for decreased range of motion left knee and tenderness to the right wrist with positive Tinel's and Phelan's signs. Diagnoses included status post bilateral total knee replacements, lumbosacral disease with right sacroiliac joint sprain, right carpal tunnel syndrome. Treatments included operative interventions, and medications. Requests for authorization for Prozac 20 mg, Norvasc, Flonase, Atarax, Robaxin 750 mg, Lunesta 3 mg, Desyrel, Lidex cream, and Zocor were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

PROZAC 20MG (IN UNSPECIFIED AMOUNTS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions.

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Fluoxetine.

Decision rationale: Prozac is the antidepressant fluoxetine. Brief courses of antidepressants may be helpful to alleviate symptoms of depression. Their usefulness in acute situations may be

limited because they may take weeks to exert their maximal effect. Antidepressants have many side effects and can result in decreased work performance or mania in some people. Fluoxetine is recommended as a first-line treatment option for major depressive disorder. In this case the documented diagnoses do not include depression. Prozac would therefore not be indicated. The request should not be authorized.

NORVASC: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Letter. Issue 113: Drugs for Hypertension.

Decision rationale: MTUS does not address this topic. Norvasc is a calcium channel blocker used in the treatment of hypertension. In this case the patient does not carry a diagnosis of hypertension and there is no documented hypertension in the medical record. Medical necessity has not been established.

FLONASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.pdr.net/full-prescribing-information/flonase?druglabelid=189#section-standard-1.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Letter, Volume 11, Issue 129, Drugs for Allergic Disorders.

Decision rationale: MTUS does not address this topic. Flonase is the intranasal corticosteroid fluticasone propionate used in the treatment of allergic rhinitis. In this case the patient did not have a diagnosis of allergic rhinitis. The patient has no complaints of nasal congestion and there is no physical examination of the nasopharynx or nares documented. The documentation in the medical record does not support the use of the medication. Medical necessity has not been established.

ATARAX: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www/pdrhealth.com/rugs/hydroxyzine-pamoate.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Medical Letter, Volume 11, Issue 129, Drugs for Allergic Disorders.

Decision rationale: MTUS does not address this topic. Atarax is the antihistamine hydroxyzine. H1-antihistamines have not been shown to be effective for atopic dermatitis. They have been used for their sedative effects for nocturnal itching. In this case In this case the patient did not carry a diagnosis of allergic disorder. There is no documentation in the medical record to support that the patient suffered from allergies. Medical necessity is not established.

ROBAXIN 750MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 63,65.

Decision rationale: Robaxin is the muscle relaxant methocarbamol. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. Side effects include drowsiness, dizziness, and lightheadedness. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) of acute exacerbations in patients with chronic low back pain (LBP). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond non-steroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. In this case the patient had been using Robaxin since July 2013. This duration of treatment surpasses the recommended short term duration of two weeks and is not recommended.

LUNESTA 3MG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia treatment.

Decision rationale: Lunesta is the non-benzodiazepine sedative hypnotic medication eszopicolone. It is a benzodiazepine-receptor agonist which works by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency. It is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. A randomized, double blind, controlled clinical trial with 830 primary insomnia patients reported significant improvement in the treatment group when compared to the control group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period. Side effects are dry

mouth, unpleasant taste, drowsiness, dizziness. Sleep-related activities such as driving, eating, cooking and phone calling have occurred. Withdrawal may occur with abrupt discontinuation. Dosing is 1-2 mg for difficulty falling asleep and 2-3 mg for sleep maintenance. The drug has a rapid onset of action. In this case there is no documentation of sleep disorder. There is also no documentation of the patient's response to the medication. Medical necessity has not been established.

DESYREL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Trazodone.

Decision rationale: Desyrel is the antidepressant trazodone. Antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Trazodone is both an antagonist at serotonin 5HT2A and 5HT2C receptors and a selective serotonin reuptake inhibitor. It is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. In this case there is no documentation of sleep disorder or the patient's response to the medication. Medical necessity has not been established.

LIDEX CREAM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.pdr.net/drug-summary/flucinnide-cream-gel-and-ointment?druglabelid=3296.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Treatment Guidelines from the Medical Letter, Volume 11, Issue 129, Drugs for Allergic Disorders.

Decision rationale: MTUS does not address this topic. Lidex is the high potency topical corticosteroid Fluocinonide. It is used for the treatment of atopic dermatitis. In this case In this case the patient did not carry a diagnosis of atopic dermatitis. There is no documentation in the medical record to support that the patient suffered from any dermatological disorder. Medical necessity is not established.

ZOCOR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.pdr.net/full-prescribing-information?druglabelid=402

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Letter on drugs and Therapeutics, Issue 1411: Drugs for Hypertriglyceridemia.

Decision rationale: MTUS does not address this topic. Simvastatin is a HMG-CoA reductase inhibitor used in the treatment of hyperlipidemia. In this case the patient does not carry a diagnosis of hyperlipidemia and there is no documentation of laboratory studies to support the diagnosis in the medical record. Medical necessity has not been established.